Learners and the Learning Context for the MHS Optimization Plan

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A Report to the Tricare Management Activity-Information Management by

The Institute for Defense Education and Analysis

in cooperation with

TELEOLOGIC
LEARNING COMPANY

In its education strategy for the MHS Optimization Plan, Tricare Management Activity-Information Management has identified the following goals:

1. To design and implement an education plan that facilitates a meaningful transfer of knowledge, practices, and skills that will lead to better force health protection and preventive health improvement.

2. To promote an understanding of the MHS Optimization Plan vision and how working to achieve it will improve health care in the MHS.

3. To motivate members of the MHS to participate in the implementation of the MHS optimization plan.

TMA-IM recognizes that to achieve these goals the educational program must be reflective of what learners perceive as the current "reality" and responsive to what learners will perceive as relevant and realistic. In other words, to motivate behavioral change by members of the MHS, the educational program must begin where the learners are today and be persuasive in demonstrating how change is beneficial to the learners, their patients, and the whole system of military health care.

To ensure that the educational program achieves these criteria, the Institute for Defense Education and Analysis (IDEA) of the Naval Postgraduate School (NPS) and Teleologic Learning Company have conducted a study of learner attitudes and the context for learning in the Military Health System (MHS). This study has consisted of three principal elements:

- An analysis of learner attitudes toward the Quick Start program,

- An intensive ethnographic study of a major Military Treatment Facility (MTF), and

- Informal interviews and focus-group discussions with MHS personnel.

Through these methods, IDEA and Teleologic have identified several findings which we believe accurately characterize a large number of the learners and the learning context for the educational effort related to the MHS Optimization plan. This report will not provide details as to the research methodology, but will focus on the findings, a justification for each finding, and our recommendations as to how each finding might influence the educational plan's design and deployment.

The Principal Findings

The research exposed several characteristics of learners and the learning context, but in examining the full range of findings it was determined that the following are closely related and are the most likely to have an impact on how the educational plan should be designed and deployed.

1. A large number of MHS professionals are familiar with, and supportive of, the principals of force health protection and population health improvement.

2. Despite principled support for the concepts of FHP/PHI, there is limited systematic attention to implementation of FHP/PHI measures.

3. The failure to develop a systematic means of implementing FHP/PHI has its origin in a profoundly fragmented culture of health care delivery.

4. The current information systems utilized by the MHS encourage fragmentation of processes and culture.

5. The current MHS financial incentive system is perceived as discouraging adoption of FHP/PHI measures.

6. The clinic is the most coherent and sustaining organizational and cultural institution of the MHS.

7. The clinic is deeply suspicious, and often antagonistic, of new approaches to health care provision or management that have their origins outside the clinic.

8. When new approaches are adopted by clinics there is a sophisticated process by which the new approaches are adapted to the specific conditions and preferences of the clinic.

9. New approaches are most often adopted and adapted when it is both very clear that there is a clinical benefit and it is very easy to implement the approach in a clinical setting.

10. The culture of a clinic consists of at least three sub-cultures: Physicians, Providers, and Protectors.

11. Protectors will be critical to the successful implementation of FHP/PHI, but are the least familiar with the concepts, and are the least likely to have current access to education, training, or professional development.

12. Primary care portals are still in the process of forming their own cultural patterns and values, and may currently be more susceptible to carefully organized outside intervention than other elements of the MHS.

A large number of MHS professionals are familiar with, and supportive of, the principals of force health protection and population health improvement.

Evidence based medicine, population based medicine, the use of clinical pathways and related concepts are positively viewed by the vast majority of physicians and nurses who were engaged by this study. Discussants evidenced familiarity with the core concepts and a readiness to implement the concepts. In some cases, there was a willingness to implement these concepts even when there was a perception that MHS financial policies would, in effect, not reward such practices.

Implementation of these and related FHP/PHI measures, however, tended to be less than systematic, and were generally not coordinated outside of individual clinics. Effective measures of success or use of recognized benchmarks were often not in place. Further, while there was often a general conceptual understanding of the importance of preventive health care and the effective management of chronic disease, staff had usually not received specific education in the concepts. In most cases tools to implement the concepts were not available.

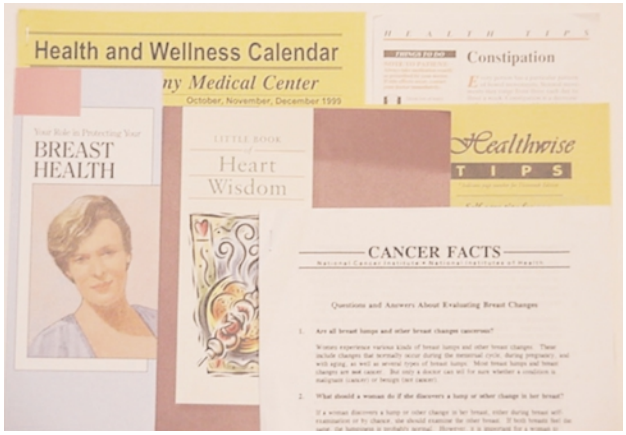
Physicians are, by and large, aware of clinical guidelines that are emerging from national efforts to reduce variation in diagnosis and treatment. Physicians are generally prepared to give serious attention to adopting such guidelines. Education and training pertaining to clinical practice guidelines are in the top three desired subject areas for all Quick Start participants. It was also the first choice of medical technicians. It was interesting to note, however, that in every case encountered by this study, national guidelines were subjected to a local process of review and revision. This process appeared necessary to ensure both a thorough understanding of the guidelines and as a means by which the local culture could validate the national process. This validation process is time-consuming and highlights the perceived need for change to be "invented or re-invented here."

The awareness of FHP/PHI concepts evidenced by physicians and nurses did not extend to most ancillary staff. Clerical staff was not aware of how preventive health care and management of chronic disease might differ from acute care, nor how clerical staff might play a role in the implementation of a transition from acute care to preventive care and effective management of chronic disease.

Awareness of FHP/PHI concepts does not translate into an awareness of the MHS Optimization Plan. Outside of the Air Force there appeared to be quite limited familiarity with the Optimization Plan. Even in the Air Force, the Primary Care Optimization training is rarely included within the larger MHS-wide efforts. Among senior administrators who were familiar with the plan, there was a lack of clarity about how the optimization plan might relate to other MHS reform efforts.

Implication for the Education Plan: Demonstrating that the MHS Optimization Plan will advance FHP/PHI should result in MHS professionals being more inclined to receive the plan positively. Ensuring that the education effort for the Optimization Plan makes available clinically relevant training in preventive health and management of chronic disease would also be well received. Providing training and education for ancillary staff is likely to be especially well received.

Despite principled support for the concepts of FHP/PHI, there is limited systematic attention to implementation of FHP/PHI measures.



The resources already committed to force health protection and population health improvement are significant. Various committees, task forces, and inter-clinic initiatives are underway. Patient education materials are prominent in most clinics. Patient seminars and participation in nationwide education efforts are common. As noted, MHS professionals are entirely cognizant of the importance of FHP/PHI concepts. If anything they resent the implication that they are not already fully engaged in FHP/PHI promotion.

Despite the enthusiasm and resources, however, there is little evidence that FHP/PHI is treated as a part of a fully integrated regime of patient care, or what the TMA-IM education plan calls a "community of care." Rather, FHP/PHI is largely ad hoc and detached from the ongoing process of clinical care. The place of FHP/PHI in the Military Health System is analogous to a very progressive corporation where community involvement and charitable activity is highly valued and encouraged, yet clearly not core to the business. As a result, the current investments made in FHP/PHI have limited impact.

At a large Military Treatment Facility both senior administrators and clinic staff communicated that "preventive health is not the job of primary care." Rather, primary care clinics were seen as lower-cost mechanisms for dealing with non-acute medical interventions.

In part this is an entirely reasonable response to having very little population-based health information. It is currently difficult and time-consuming to develop accurate descriptions of the beneficiary population and their health patterns. At the clinic level generation of this information is beyond the competence of administrative and most clinical staff. It was interesting that at the Quick Start program data analysis techniques was among the most high-demand topics. This demonstrates both the readiness and the lack of current capability.

Even at the major MTF, however, it required nearly three full-time senior uniformed staff to generate the most general overviews of medical utilization and population profiles. The current information technology and information management tools are so ill-suited for tracking and managing FHP/PHI that they actually discourage effective implementation of a conceptual goal that most MHS professionals endorse.

Implication for the Education Plan: There is a need to provide basic information or easy-to-use tools related to gathering information and accurately describing the population being served by a primary care team or clinic. MHS staff should be educated both in data collection and data analysis specifically to support population-based health care. Education should also focus on how FHP/PHI is a critical element in an integrated process of clinical care and is fundamental to the practice of primary care.

The failure to develop a systematic means of implementing FHP/PHI has its origin in a profoundly fragmented culture of health care delivery.

The physician's workshop continues to be the most well-understood and fully supported organizational element in the Military Health System. The specialists workshop is especially well understood and supported. The largest medical treatment facilities are more or less dysfunctional as systems. It is primarily at the disease-oriented clinic level that self-sustaining systems and processes are developed and implemented.

There is a strong tendency to view the patient less as a person-in-community and more as a repository of potential or actual morbidity. If the diseases are well treated the person and community will benefit, and this benefit is certainly motivational to providers and their supporters. But the focus on the diagnosis and treatment of disease, a natural outgrowth of a rigorous process of medical education, is the organizing value of clinics. This value is largely unarticulated and unexamined, but it is powerful.

Within the large MTF involved in this study senior management had done an extraordinary job of emphasizing and developing an authentic institutional esprit de corps. In this institution there were various mechanisms, and generally effective mechanisms, for encouraging communication and cooperation between the clinics. As a result, there was less fragmentation than is the case in many other military or private settings. Yet even here, the sense of competition, not-invented-here, and level of misinformation between clinics was quite substantial.

Given the requirements of modern medicine there is a suspicion that what works with other diseases will not work on "my" disease. Further, this suspicion is often empirically true. As a result, there is a very realistic rein-

forcement of the value of fragmentation. If the organizing principal of health care delivery is treatment of disease, there are valid reasons for fragmentation.

If, however, the organizing principal of health care delivery is Force Health Protection/Population Health Improvement this fragmentation does not contribute to achieving the designated goal. If FHP/PHI is the goal, it is the health of the whole community that is the organizing value.

Intellectually most MHS providers would agree with the value of community health, but their behavior is focused mostly on treatment of disease. This behavior is partly habituated by the educational and cultural processes by which they entered the health care profession. It is further reinforced by the extraordinary daily demand of disease intervention. Finally, the value is sustained by having very effective tools for disease intervention and very primitive, if any, tools for population based health care. As a result the current MHS professionals are inclined to continue doing what they have been well trained to do, what their patients are demanding, and what they have the tools to do very well.

If the principal value of the MHS is to change from disease intervention to FHP/PHI it will be necessary to give health care professionals the training and the tools that will allow them to treat populations at least as well as they treat diseases.

Implication for Education Plan: There is a need to help MHS professionals recognize how the value of disease treatment can be an unintended impediment to the implementation of FHP/PHI concepts. There is also a need to provide MHS professionals with education and tools that will allow them to gather information, diagnose, treat, and track the result of treatment that is focused on a defined population. Without such tools and the skills to use such tools, it is unlikely that the current value of disease treatment will be affected.

The current information systems utilized by the MHS encourage fragmentation of processes and culture.

Currently CHCS is an ubiquitous information system across the MHS. Despite this commonality, it is remarkable how differently this system is utilized from clinic to clinic. Further, because most clinics find CHCS entirely insufficient for local purposes, entirely home-grown parallel systems are developed. As a result, important information and processes are never available for system-wide (or even facility-wide) examination. Variation in use of CHCS, and the development of entirely independent (often non-automated) information systems, reinforce and amplify the fragmentation of the MHS. These dysfunctions also result in an extraordinary application of person-hours to work that results in very little actual improvement in health care.

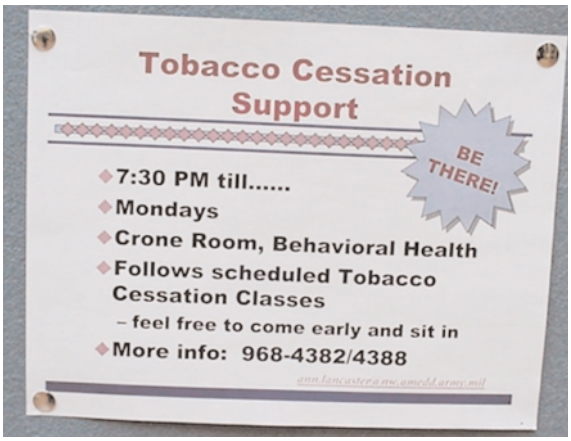
It is likely, given current attitudes to CHCS, that CHCS II will be received with significant skepticism. Among the most common complaints regarding CHCS are:

- Difficult interface.
- Lack of ability for customization to local needs.
- Lack of interface with CIS and other information systems.

- Dependence of text inputting rather than algorithmic (check-off) inputting.
- Dependence on arcane codes rather than natural language or check-offs.
- CHCS is all input and no output, in other words there is no perceived clinical benefit to accurate input of information.

It is widely noted that there has been very little systematic training provided on CHCS. There is significant doubt that anyone really knows how the system is "supposed to be used." Each new employee receives CHCS training on the job from someone who was largely self-taught on the system.

It was interesting that at the Patient Admissions and Disposition (PAD) unit of the large MTF involved in this study that it was noted that there is very little incentive to use CHCS accurately. In the opinion of the PAD personnel, providers see the CHCS merely as a time sink. Providers are unaware of how the system is supposed to work, the potential benefits if the system did work, or the problems that are currently accruing because the system is not being utilized.



In another administratively focused unit, staff noted that, "when selectable, pre-developed consultation phrases were available for doctors to describe the patient visit and outcomes, doctors tended to choose standard responses that were not specific or descriptive enough. Also, the software allowed consultation notes to be "carried forward," and with these doctors, the same notes appeared in every report on the patient, thus the 'notes' were useless."

Unless CHCS II is effectively positioned as addressing these common complaints and perceptions, it is unlikely that it will make a positive contribution to MHS Optimization.

Because the current information systems are utilized in such different ways and result in so many clinic-specific parallel information systems, the fragmentation of the MHS is actually deepened as a result of the current information systems.

As a tool specifically designed to address problems in a first generation version, CHCSII has gone through several extensive reviews by panels of real physicians and providers. The interface, designed with a windows-based approach, encourages easily accessible and useful fields and organization of data and information. In testing, the utility of the data fields and the adaptability of the tool to specific needs was emphasized. At least among the Quick Start participants observed, there was great enthusiasm for CHCSII and appropriate training and education to support its implementation. The primary drawback at this point is the timing of availability. It is conceivable that some MTFs will not have CHCSII installed with training within the next year—possibly even within the next two years. The long delay between policy and practice changes and the availability of the tools to support such changes is problematic.

Implication for Education Plan: It may be most advisable to stagger the implementation of education to more closely correspond with the availability of CHCSII than to push forward on disparate schedules that may foster frustration and disillusionment with the Optimization Plan. At the very least, if CHCSII is not available at roughly the same time as the educational programming is presented, then focused and specific attention needs to be given to how the current tools, if used properly, will assist in optimizing care. Other incentives for using the current tools should also be clearly articulated. Efforts at addressing problems with the current information systems and tools should be transparent. As noted in the responses from Quick Start participants, there is a strong desire to better understand—and by implication to use more effectively--the information systems of the MHS.

The current MHS financial incentive system is perceived as discouraging adoption of FHP/PHI measures.

There is a wide spread impression that when FHP/PHI is actually practiced it reduces the financial resourcing of the clinic or MTF. Again and again this study heard MHS professionals indicating that effective disease management protocols were reducing the patient-count on which budgets would be determined. There was a sense that there is no financial incentive that rewards successful efforts at reducing non-appropriate utilization.

One senior administrator offered the following perspective:

> We are being driven and we want to be like a civilian HMO. But we're not like a civilian HMO. Our workload accounting does not provide incentivization to move from a volume driven health care mode to a population health mode. Incentives should mirror the optimization plan. Currently there is no way to reward a department for being super-efficient. In fact they are punished with less resources.

Another senior physician commented:

> There is a philosophical disconnect between staffing models and the MHS optimization plan with the metrics used for staffing based on volume-seen not prevention.

It was also reported, however, that the current system will recognize and incent the good practice of FHP/PHI, but that the protocols for providing this care and receiving financial credit are not well understood and awkward to report. As a result, the negative financial sanction is real, even if unintended and avoidable.

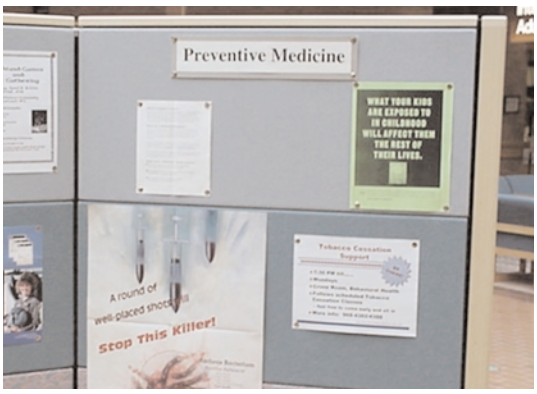
There is clearly a lack of understanding in how full engagement in FHP/PHI will result in real financial support for either the local clinic or the system as a whole. As a result there is a lack of focus or enthusiasm for implementation. In one case a department director noted, "We are implementing good disease management because it is the right thing to do, even though it is not in our financial self-interest."

Implication for Education Plan: There must be early, detailed, and persuasive information and education on TRICARE 3.0 that will explain how to ensure that financial resources will flow to organizations that effectively implement the principles of force health protection and population health improvement.

The clinic is the most coherent and sustaining organizational and cultural institution of the Military Health System.

As has already been suggested above, for a number of reasons the clinic is the real focus of most health care organizations. It is in the clinic that health care professionals most often practice what they understand to be their principal role. It is, as a result, largely the values of the clinic that define the values of the health care organization.

Because of the disease focus of most clinics, the clinics are also highly focused on the physicians who specialize in treating the disease. In this context it is not uncommon for the specialists to become the personification of the clinic's purpose. Protecting and extending the work of the specialist can become the most tangible goal. The immediate needs of patients with the disease, the real expertise that exists in treating the disease, and the team-work that is required to effectively apply the expertise all combine to create a strong sense of meaningful purpose.



Nurses, physician assistants, pharmacists, and clerical staff all show a strong tendency to link their professional identities to the purpose of the clinic and the personalities of the senior physicians in the clinic. Anything that is seen as complicating or threatening the clinic is, not surprisingly, considered an attack on the core values of the health care professional.

Among the most ardent defenders of the clinic as the focus of value are clerical staff. While most physicians and nurses are, when asked, somewhat uncomfortable admitting such a strong value system is in place, most clerical staff are explicit about both the value system and its influence being entirely appropriate.

The possibility that this value system might conflict with FHP/PHI is not apparent to most MHS professionals. But to the extent this value system is widely in place, it will be quite difficult to shift the focus from disease intervention to FHP/PHI.

Implication for Education Plan: There is a significant likelihood that the system's focus on the clinic is entirely too strong to challenge. It may be more successful to seek to advance FHP/PHI by embracing the clinic as the locus of change.

The clinic is deeply suspicious, and often antagonistic, of new approaches to health care provision or management that have their origins outside the clinic.

Clinics are highly conservative cultures. Any attempt at behavioral change that does not reflect the values of the clinic is likely to be resisted or at least resented. The more geographically distant the source of change, the

higher will be the skepticism. New ideas are most likely to be adopted based on the experience and recommendation of geographically proximate clinics that are focused on the same disease.

Implication for Education Plan: Simply because the plan is being developed by Washington it will have to overcome some inherent resistance. Cultivation of local champions will ease its acceptance.

When new approaches are adopted by clinics there is a sophisticated process by which the new approaches are adapted to the specific conditions and preferences of the clinic.

Change most often comes to the clinic through the advocacy of a physician-champion. There are certainly examples of non-physicians being the first person in the clinic to identify the new approach, but these individuals almost always enlist a physician-champion. For example some nurses regularly approach senior physicians specifically to serve as champions. The same nurses also noted that using too many senior doctors (for example, on a committee) made the group too "top-heavy" and was not a good mix for getting things done as a group.

However it may happen, the physician becomes aware of a new or different clinical practice and shares this information with Senior Clerks, Supervising Nurses, and/or Physician Assistants.

At the invitation of the physician-champion, staff from a clinic that has already adopted the new approach visit the clinic or otherwise communicate their experiences with their colleagues. This process of shared communication is often limited to physicians or other clinicians.

Through a largely informal process of collegial consensus senior physicians and other clinicians decide how to implement the new approach. At this point, if there are administrative implications, clerical staff may be involved in developing procedures, templates, or other management devices. It is just as likely for these new procedures to be created from scratch as for clerical staff from the originating clinic to be consulted.

In most cases adaptations are applied to the original approach. While many of these may reflect authentic differences in the local conditions of the two clinics, it appears just as likely that these are also a means for the adopting clinic to claim the new approach as its own. If the origin of the new approach is remembered at all, emphasis will be placed on how the local adaptation has substantially improved what was adopted from elsewhere. It is even more likely that the physician-champion will be identified as the source of the change, and the outside influence forgotten.

Implication for Education Plan: The role of the physician-champion and local adaptation should be built into the change process on which the education plan is developed.

New approaches are most often adopted and adapted when it is both very clear that there is a clinical benefit and it is very easy to implement the approach in a clinical setting.

A smaller MTF nearby the major Medical Treatment Facility involved in this study had developed a set of written telephone triage guidelines. These guidelines had been effectively applied in that smaller setting. Using these guidelines, a senior physician at the large MTF's Adult Primary Care Clinic (APCC) developed an algorithm and a set of desktop screens to assist telephone triage nurses and clerks ask patients key questions and make reasonable determinations as to appropriate care. There was significant pride and attention given this local adaptation. Several months after the adoption of the algorithm and desktop system by the APCC, the large MTF's Family Practice Clinic determined that it would also adopt the system. Adaptation by the Family Practice Clinic is likely but had not been finalized at the time of this study.

It was emphasized that this new approach was adopted much more readily than most because

1. A nearby clinic had demonstrated its efficacy to clinical practice.
2. A sister clinic had enhanced the tool and made it even easier to use.
3. Customization and adaptation was allowed.

Several MHS professionals involved in this study commented on the absolute need for administrative tools to be fully integrated with clinical practice, and the need to automate administrative procedures through the use of algorithms rather than through guidelines. One administrator commented, "Physicians embrace practice guidelines, but implementation is often too difficult even when the guidelines are online. They are very interested in best practices, dedicated, but the day-to-day process is so intense that unless you make it easy, automatic it will not be done."

Implication for Education Plan: Significant attention should be given to how PHOTO can be customized to meet local, or even personal, preferences.

The culture of the clinic consists of at least three sub-cultures: Physicians, Providers, and Protectors.

As has been noted, in the traditional disease-focused clinic specialty physicians play a singularly influential role. The specialty clinic is essentially the physician's workshop. In these settings physicians are undoubtedly the primary decision-makers and culture builders.

Other providers including nurses, physician assistants, social workers, and pharmacists, play critical supporting roles to the physicians. Moreover, the provider sub-culture features a significant level of autonomy especially in the provision of primary care. Nurses, in particular, and other providers more generally recognize that they have a unique capability to provide care to the whole person. Where the specialty physician is profoundly respected for his expertise in disease treatment, these providers are aware that time and personality at times result in the physician neglecting the social and emotional care of the patient. In many cases providers are well positioned to address issues of preventive care and management of chronic disease, but it was not common to find them

doing so within the context of the clinic. (The provider sub-culture tends to provide the leadership for FHP/PHI measures that take place outside clinics.) The failure of providers to offer such guidance is likely a result of the clinic culture not giving significant attention to such issues and the lack of specific professional development.

Implication for Education Plan: There is a significant opportunity to encourage providers to see that they can extend their tradition of holistic care to the practice of FHP/PHI.

Protectors will be critical to the successful implementation of FHP/PHI, but are the least familiar with the concepts, and the least likely to have current access to education, training, or professional development.

Within the culture of the clinic the physician is seen as needing protection. There is a significant commitment by the provider sub-culture to minimize a physician's involvement on anything but a top priority task. But where this protective tendency is most apparent is with clerical staff. Clerical staff can feel a commitment to protecting the physician that is so strong that it may be perceived as being unsympathetic to patients. But if appropriately directed, appointment clerks, file clerks, lead clerks, and other ancillary staff are a critical and significantly underutilized resource for accomplishing MHS Optimization.

Members of this sub-culture who participated in the Quick Start program indicate a significant interest in learning more about managed care, MHS information systems, and data analysis. As a group, the Protectors are often highly motivated and hard-working individuals who make significant contributions despite having limited training or education in health care.

It is recognized that the MHS must significantly increase the support physicians receive from ancillary staff. Clearly defining the roles of ancillary staff and fully utilizing them within the scope of practice may result in a doubling of ancillary staff in many MTFs. Especially as a new generation of Protectors enter this system it is important to provide them with much more explicit education in how their careers can do more than protect the physicians and actually advance the goals of FHP/PHI.

Implication for Education Plan: Develop programs that are responsive to the interest of this group of learners and that serve to more fully integrate these learners and their roles in to the community of care.

Primary care portals are still in the process of forming their own cultural patterns and values, and may currently be more susceptible to carefully organized outside intervention than other elements of the MHS.

Primary care portals do not yet reflect all of the characteristics of other clinics. The lack of a disease focus fundamentally alters the cultural outlook of the primary care portal. Physicians do not appear to dominate primary care portals as completely as specialty clinics. The Provider sub-culture is potentially much stronger in primary care clinics.

Without the disease focus there is the opportunity for primary care clinics to focus much more on the community of care, rather than the treatment of disease. This is not yet the case, but with appropriate education and management it may be possible to encourage such a focus.

Presumably, the primary care portals are the principal tools of FHP/PHI. Unfortunately, the primary care portals encompassed in this study were much more a first line of defense for the specialty clinics, rather than a proactive force for advancing sound preventive care and management of chronic diseases. But there is little evidence that the primary care portals would resist this broader and critically important role.

There was limited evidence that Primary Care Teams (PCTs) have, in most situations, become more than organizational units. There can be substantial mobility in PCTs that has undermined their emergence as a cultural entity, and given their relatively recent introduction it is not surprising that the values and patterns of PCTs are still under development.

Implication for Education Plan: The Primary Care Portals are probably the most promising target for education focused on behavioral change consistent with MHS optimization.

Overview and Recommendations

The preceding analysis, while informed by some quantitative studies, is largely qualitative. Its purpose is to describe the current condition of the Military Health System's learners and the learning context for the MHS Optimization plan. The analysis takes no position on whether the learners' current perception of reality accurately reflects policy or objective reality. In learning, the subjective perception of learners is reality. To be effective, the learning process must in some effective way accommodate the current reality of the learner. Many of the most ambitious educational efforts often fail by focusing on what "should" be the case, rather than what is the case.

As Tricare Management Activity-Information Management prepares for the next phase of developing the education plan, IDEA and Teleologic recommend serious attention to the following elements:

- Audience: The clinic is the target. Primary care clinics (or portals) and PCTs within these clinics are the most promising audiences in terms of readiness for change. By focusing on this key cultural entity and the PCTs within this entity, behavioral change consistent with the MHS Optimization Plan is made much more likely. It may be possible to target specific "thought-leading" clinics that will become effective change agents in their geographic and disciplinary "neighborhoods." Making the necessary investment to effectuate authentic change in one thought-leading clinic is more likely to result in widespread change than in superficial engagement with a wide range of clinics.

- Champions of Change: Identify physicians and other providers who have a track record as champions of change. Cultivate their support. Solicit their involvement. Recruit their endorsement. Put them forward as advocates for MHS Optimization.

- Localize Information and Process: Optimize the possibility for local adaptation consistent with system-wide goals. This includes the education process, information management tools, and even the perceived source of change. To the extent that MHS Optimization is perceived as a local initiative that has Washington's support, rather than a Washington idea seeking local support it is much more likely that local audiences will engage the possibility of change.

- Localize population health data: Every education event should provide, and give significant attention to, accurate data on the health condition of a defined local population. Only when such data is available at a reasonably granular level is it likely the delivery of the education plan will be well-received and lead to behavioral change that truly embraces FHP/PHI.

- Localize financial benefit data: Every education event should provide, and give significant attention to, how the MHS Optimization Plan and TRICARE 3.0 provides for adequate financial incentives to support the local application of FHP/PHI. Education can and should give very specific instruction and information on how to maximize work-load credits under FHP/PHI. Local examples and projections as to local impact will be important.

- Localize CHCS II and PHOTO: To the extent technically possible, specific instruction should be given in how to effectively localize the new tools being introduced. This localization will take place in any case. Guiding and coordinating the localization process is more likely to result in adoption and utilization of the new systems in a way that advances system-wide goals.

- Emphasize the Community of Care: Primary Care Managers and Teams are the shock troops of a new and better way to advance the health of individuals and communities through integrated and holistic measures. Primary care clinics and PCTs should come to see themselves as an elite and purposeful new culture. They should take pride and draw strength from how they are differentiated from the old culture of disease intervention. The greater recognition given non-physicians in this new culture should be highlighted. This is unlikely to be threatening to physicians, and should be empowering to other providers and what this report has called protectors. While there is an intellectual readiness to embrace the concepts of FHP/PHI, the community of care analogy with the iconic small town physician should be heavily emphasized. There is a need to capture the imagination of Primary Care Managers and Teams in order to counter the very strong attraction of the values of disease intervention.

- Emphasize prevention and management of chronic disease: Currently primary care clinics and teams are inclined see their role largely as the screening and triage operation for the specialty clinics. A significant effort should be given to making prevention and management of chronic disease the substantive focus of primary care clinics and teams. Just as the specialty clinics derive a sense of high value and purpose from treatment of their specialty diseases, the primary care clinics and teams should come to see themselves as "specialists" in prevention and effective management of chronic diseases. Provide these new players a powerful parochialism of their own that advances a non-parochial purpose.

None of these recommendations are cause for a major revision in the current TMA-IM education plan. Adoption of these recommendations would only serve to give the current plan a more specific focus. The proposed test of the education plan at Tripler Army Medical Center provides a good opportunity to evaluate the effectiveness of these recommendations.